

**NEW PATIENT QUESTIONNAIRE**

Patient Identification

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_  
(if different from referring doctor)

**Please briefly summarize your health concern for today's visit.**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

**What is the main goal of today's visit?**

---

---

---

**How long have you had your most bothersome problem?**

---

**NEW PATIENT QUESTIONNAIRE**

Patient Identification

**Pelvic Floor Distress Inventory – 20**

**Instructions:** Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by putting an X in the appropriate box or boxes. While answering these questions, please consider your symptoms over the last 3 months.

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)	NO	YES	If <b>YES</b> , how much does it bother you?			
			1 Not at all	2 Some what	3 Mod-erately	4 Quite a bit
Do you _____?						
1. Usually experience pressure in the lower abdomen?						
2. Usually experience heaviness or dullness in the pelvic area?						
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?						
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?						
5. Usually experience a feeling of incomplete bladder emptying?						
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?						
<b>Colorectal-Anal Distress Inventory 8 (CRADI-8):</b>						
7. Feel you need to strain too hard to have a bowel movement?						
8. Feel you have not completely emptied your bowels at the end of a bowel movement?						
9. Usually lose stool beyond your control if your stool is well-formed?						
10. Usually lose stool beyond your control if your stool is loose?						
11. Usually lose gas from the rectum beyond your control?						
12. Usually have pain when you pass your stool?						
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?						
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?						
<b>Urinary Distress Inventory 6 (UDI-6):</b>						
15. Usually experience frequent urination?						
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?						
17. Usually experience urine leakage related to coughing, sneezing, or laughing?						
18. Usually experience small amounts of urine leakage (that is, drops)?						
19. Usually experience difficulty emptying your bladder?						
20. Usually experience pain or discomfort in the lower abdomen or genital region?						

<b>Part I: Urinary Stress Symptoms (MESA)</b>	<b>0 Never</b>	<b>1 Rarely</b>	<b>2 Some- times</b>	<b>3 Often</b>
<i>(Would you say...)</i>				
1. Does coughing gently cause you to lose urine?				
2. Does coughing hard cause you to lose urine?				
3. Does sneezing cause you to lose urine?				
4. Does lifting things cause you to lose urine?				
5. Does bending cause you to lose urine?				
6. Does laughing cause you to lose urine?				
7. Does walking briskly or jogging cause you to lose urine?				
8. Does straining, if you are constipated, cause you to lose urine?				
9. Does getting up from a sitting to a standing position cause you to lose urine?				

<b>Part II: Urinary Urge Symptoms (MESA)</b>	<b>0 Never</b>	<b>1 Rarely</b>	<b>2 Some- times</b>	<b>3 Often</b>
<i>(Would you say...)</i>				
1. Some women receive very little warning and suddenly find that they are losing, or are about to lose urine beyond their control. How often does this happen to you?				
2. If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?				
3. Do you lose urine when you suddenly have the feeling that your bladder is very full?				
4. Does washing your hands cause you to lose urine?				
5. Does cold weather cause you to lose urine?				
6. Do drinking cold beverages cause you to lose urine?				

<b>PGI-S</b>	<b>1 Normal</b>	<b>2 Mild</b>	<b>3 Moder- ate</b>	<b>4 Severe</b>
<b>Check the one number that best describes how your urinary tract condition is now:</b>				

**NEW PATIENT QUESTIONNAIRE**

**SECTION 1: URINARY SYMPTOMS**

How often do you typically urinate during the day?

Every \_\_\_\_ hours, \_\_\_\_ # of times per day.

How often do you urinate during the night after going to bed? \_\_\_\_ # of times per night.

Do you TYPICALLY have pain or burning when you urinate?  No  Yes

Do you TYPICALLY have pain when your bladder is full?  No  Yes

If so, does the pain resolve when you empty?  No  Yes

Do you leak urine?  No (Skip to Section 2)  Yes

TYPICALLY, how many times do you leak urine during the daytime? (check one)

Never  \_\_\_\_ times per **(check one)**  day /  week /  month

In the last month, how many times have you wet the bed at night?

Never  \_\_\_\_ times per **(check one)**  day /  week /  month

Do you wear protection for urine loss?  No **(skip to Section 2)**  Yes

Use the following table to indicate how many of the following pads you use during day and night?

	Tissue	Mini-pad/liner	Regular pad	Heavy pad or diaper
DAYTIME				
NIGHT TIME				

When you change your pads, are they:  Dry  Have a few drops  Wet  Soaked

**SECTION 2: BOWEL SYMPTOMS**

How many bowel movements do you typically have each week? \_\_\_\_

Do you have trouble with bowel movements? Diarrhea?  No  Yes Constipation?  No  Yes

Do you have accidental bowel leakage?  **No (skip to next section 3)**  Yes

In a TYPICAL month, how often do you have accidental bowel leakage? # \_\_\_\_ times per month

Do you use pads or devices for bowel leakage?  No  Yes, # \_\_\_\_ per day

**SECTION 3: TREATMENT HISTORY**

Have you had prior treatment for PELVIC PROLAPSE, URINARY or BOWEL problems?

**No (skip to Section 4)**  Yes – use the table below to indicate which treatments you have tried.

Treatment	Tried
Pelvic muscle exercises (Kegel or pelvic floor physical therapy)	<input type="checkbox"/> No <input type="checkbox"/> Yes Did it help?
Medications (Check one's you have tried)	<input type="checkbox"/> Darifenacin (Enablex) <input type="checkbox"/> Oxybutynin (Ditropan or Ditropan XL, Oxytrol patch, gelnique)
	<input type="checkbox"/> Tolterodine (Detrol) <input type="checkbox"/> Fesoterodine (Toviaz)
	<input type="checkbox"/> Solifenacin (Vesicare) <input type="checkbox"/> Trospium (Sanctura)
	<input type="checkbox"/> Mirabegron (Myrbetriq) <input type="checkbox"/> Other: _____
Reason for stopping	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Help
Pessary or vaginal device	<input type="checkbox"/> No <input type="checkbox"/> Yes Did it help?

Patient Identification

**NEW PATIENT QUESTIONNAIRE**

**SECTION 3: TREATMENT HISTORY (Continued)**

Patient Identification

	Date	Procedure
Pelvic floor surgery or procedure		

**SECTION 4: OBSTETRIC AND GYNECOLOGIC HISTORY**

No. of Pregnancies: \_\_\_\_\_ Vaginal deliveries: \_\_\_\_\_ Cesarean births: \_\_\_\_\_ Miscarriages or abortions: \_\_\_\_\_

If you have had a vaginal delivery:

- Please tell us the weight of your largest baby born vaginally: \_\_\_\_\_ pounds \_\_\_\_\_ ounces
- Please indicate if you have ever had the following:
  - Forceps delivery     Vacuum delivery
  - Severe tear after delivery that involved the anal sphincter/rectum

**Check** the category below to indicate when you went through menopause:

<input type="checkbox"/> Haven't yet gone through menopause    ➔	Are you using any form of contraception? <input type="checkbox"/> No <input type="checkbox"/> Yes: List: _____ Have you completed your family? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure
<input type="checkbox"/> Going through menopause now	<input type="checkbox"/> Yes <input type="checkbox"/> Unsure
<input type="checkbox"/> I went through menopause at age _____ yrs    ➔	After menopause, did you use hormone replacement therapy? <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current After menopause, did you use vaginal hormone therapy? <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current

**SECTION 5: SEXUAL FUNCTION**

Pelvic floor problems often interfere with sexual relations. In order to best treat you, it is important to ask questions about your sexual health. If you feel uncomfortable answering these questions prior to your appointment, please discuss these issues with your provider at the time of your initial visit.

- Is your sex life satisfactory for you?     No     Yes
- Do you have any sexual concerns that you would like to address?     No     Yes
- Are your sexual activities limited by your pelvic floor problem?     No     Yes
- Are you sexually active at this time in your life?     **No (skip to section 5)**     Yes
- Does your sexual activity include vaginal intercourse?     No     Yes
- During intercourse, when do you leak urine?     Never     With penetration     With orgasm
- When do you have pain with intercourse?     Never     With deep penetration     With entry

**NEW PATIENT QUESTIONNAIRE**

**SECTION 6: MEDICATIONS**

**Allergy to Medication :**

Yes (Please list below)     **NO (Skip to Current**

Patient Identification: \_\_\_\_\_

List your medication allergies	Reaction

**Current Medications:**

Please list your CURRENT medications including supplements	Dose	Times per day	Approximate Start Date

**SECTION 7: MEDICAL HISTORY** – Please mark with an X if you have had any of the following medical conditions:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Heart attack  | <input type="checkbox"/> High blood pressure                         |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Blood clots (deep venous thrombosis/<br>pulmonary embolism) | <input type="checkbox"/> Recurrent urinary tract infections          |
| <input type="checkbox"/> Anticoagulation therapy       | <input type="checkbox"/> Pelvic radiation  | <input type="checkbox"/> Glaucoma                                    |
| <input type="checkbox"/> Neurologic disease            | <input type="checkbox"/> Back injury   | <input type="checkbox"/> Hypothyroid                                 |
| <input type="checkbox"/> Stomach Ulcer                 | <input type="checkbox"/> Back pain or sciatica                                       | <input type="checkbox"/> Jehovah's witness/<br>refuse blood products |
| <input type="checkbox"/> Cancer: Type: _____           |  |  |
| <input type="checkbox"/> Other medical problems: _____ |  |  |

**SECTION 8: SURGICAL HISTORY** – Please list ALL past surgeries

Date	Surgery	Comments

Please provide more details here if needed: \_\_\_\_\_

**NEW PATIENT QUESTIONNAIRE**

Patient Identification

**SECTION 9: FAMILY HISTORY**

No Family Medical History       History unknown/Adopted

	High BP	Diabetes	Heart Attack	Stroke	Cancer	Incontinence	Prolapse
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide more details here if needed:

---



---



---

**SECTION 10: SOCIAL HISTORY**

Tobacco Use:  Never     Current: Packs/day \_\_\_\_\_  Prior (quit): Quit date: \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_

Smokeless Tobacco:  Never     Current     Former

Alcohol Use:  No     Yes

If yes, what do you drink? \_\_\_\_\_ and how many ounces (oz.) per week? \_\_\_\_\_

**SECTION 11: REVIEW OF SYSTEMS – Please check all that apply**

- Constitutional:**       Unusual fatigue       Weight loss       Loss of appetite
- Eyes:**                 Double vision       Blurred vision       Glasses/Contacts
- Ears, Nose & Throat:**     Deafness       Hoarseness       Ringing in ears
- Cardiac:**               Chest pain       Irregular beats       Palpitations
- Pulmonary:**          Shortness of breath     Chronic cough       Wheezing
- Gastrointestinal:**     Blood in stool       Chronic diarrhea     Black stools
- Musculoskeletal:**     Pain in joints       Lower back pain     Muscle weakness
- Skin:**                  Bruising       Hair loss       Unexplained rash
- Neurologic:**          Seizures       Frequent Headaches     Numbness
- Psychiatric:**         Depressed       Difficulty Sleeping     Memory Loss
- Endocrine:**           Hot flashes       Dry skin       Sensitive to heat/cold
- Blood Diseases:**     Anemia       Bleeding problem     Enlarged lymph gland
- Allergy:**               Sinus problems       Allergic reaction       Conjunctivitis

**URINARY DIARY**

Patient Identification

**PRIOR TO YOUR VISIT WITH US:**

PLEASE COMPLETE THIS BLADDER DIARY IF YOU ARE SEEKING HELP FOR ANY OF THE FOLLOW URINARY PROBLEMS:

FREQUENCY, URGENCY, LEAKAGE (Incontinence) or WAKING AT NIGHT TO URINATE.

This diary is a record of your fluid intake, voiding (urinating), and incontinence (leakage of urine).

**INSTRUCTIONS:**

1. Choose a 24-hour period of time to keep this record. You will need to measure every void (urination) and the amount of all liquid you drink during those 24 hours.
2. Begin your record with the FIRST void when you arise from sleep (see the example below).
3. Use a standard 1 or 2 cup plastic measuring device and record in ounces or milliliters.
4. After voiding, you may discard that urine after you measure it (no need to collect the urine).
5. Record any leakage of urine and whether this was a small (1), moderate (2), or severe (3) leakage episode. Indicate whether you had an urge to urinate at the time of leakage.

Example:

<b>TIME</b>	<b>Amount Voided</b>	<b>LEAK AMOUNT</b> 1 – small 2 – moderate 3 – severe	<b>ACTIVITY DURING LEAK</b>	<b>URGE PRESENT?</b> Yes or No	<b>FLUID INTAKE</b> Amount and Type
6:45A	500 mL		Just awakened		
7:00A					6 ounces orange juice
8:45A		2	Turned on water		16 ounces coffee



**URINARY DIARY**

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Identification

<b>TIME</b>	<b>Amount Voided</b>	<b>LEAK AMOUNT</b> 1 – small 2 – moderate 3 – severe	<b>ACTIVITY DURING LEAK</b>	<b>URGE PRESENT?</b> Yes or No	<b>FLUID INTAKE</b> Amount and Type